Please forward this form along with the physician's prescription.

Physical Therapy Pre-Certification Form
Additional Visits/Spinal

QualCare, Inc.
30 Knightsbridge Road
Piscataway, NJ 08854-3754

Patient's Name: ID Number: Group:

Date of Birth: Age: Other Medical Insurance Yes ☐ No ☐

If yes, Name: Policy Number

If MVA/Other: Date of Accident: Ins. Name Phone: Policy#

Date of Re-Evaluation: **Number of Completed Visits:**

Primary symptoms, with or without radiation:

Duration: Frequency: ☐ Constant ☐ Intermittent

Quality: ☐ Ache ☐ Burning ☐ Numbness ☐ Sharp ☐ Dull ☐ Spasm

Pain Level (0-10) Best Worst Exacerbated by:

Onset Date: Injury due to: ☐ MVA ☐ WC ☐ Other N/A ☐

	Cervical Spine			**Thoracic Spine**			
	ROM Active	ROM Passive	MMT	ROM Active	ROM Passive	MMT	
Flexion							
Extension							
Rt. Lateral Flexion							
Left. Lateral Flexion							
Rt. Rotation							
Left Rotation							

	Lumbar Spine			
	ROM Active	ROM Passive	MMT	Functional Limits Mild ☐ Moderate ☐ Severe ☐
Flexion				Improved ROM Yes ☐ No ☐
Extension				Improved Strength Yes ☐ No ☐
Rt. Lateral Flexion				Improved Functional Performance Yes ☐ No ☐
Lt Lateral Flexion				Adherence to HEP Yes ☐ No ☐
Rt Rotation				Radiculitis Yes ☐ No ☐
Lt Rotation				Parethesis Yes ☐ No ☐

Additional Information/Special Testing/Deficits:

Diagnosis: (List by ICD 9 Code)

1. 2. 3. 4.

Goals Short Term Long Term

Short Term	Long Term
1.	1.
2.	2.
3.	3.
4.	4.

Provider: ____________________ **Tax ID Number:** ____________________

Phone Number: **Contact Name/ Fax Number:**

Pre-Certification Department Fax Number: 732-562-1023

PPO 800-992-6613 (Phone) HMO Network 800-254-0130 (phone)